STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner

v **File No. 121464-001**

Priority Health Insurance Company
Respondent

Issued and entered
this 31ST day of October 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On May 18, 2011, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* The Commissioner accepted the Petitioner's request for review on May 25, 2011.

The Petitioner receives health care benefits under a policy issued by Priority Health Insurance Company (PHIC). The Commissioner notified PHIC of the external review and requested the information it used to make its final adverse determination. The Commissioner received PHIC's response on June 2, 2011.

The issue in this case can be decided by applying the terms of PHIC's *PPO Insurance Policy* (the policy). The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

On November 11, 2010, Petitioner went to her physician's office because she was unable to breathe. Her physician told her to go to XXXXX Hospital as it was the closest hospital. XXXXX's Hospital is not in PHIC's network of providers. She was admitted for treatment and

subsequently discharged on November 13, 2010. PHIC provided coverage for Petitioner's treatment at the non-network benefits level applying the hospital charge to the Petitioner's non-network deductible.

Petitioner appealed through PHIC's internal grievance process, requesting PHIC provide coverage at the in-network benefit level. PHIC affirmed its original decision and issued its final adverse determination on April 29, 2011.

III. ISSUE

Did PHIC correctly process the Petitioner's emergency hospitalization under the policy's non-network benefit provision?

IV. ANALYSIS

In her request for external review, Petitioner states that her in-network doctor sent her to the emergency room of an out-of-network hospital where she was admitted and treated for chronic obstructive pulmonary disease during her stay.

In its final adverse determination dated April 29, 2011, PHIC denied coverage at the in-network level explaining:

> . . . Priority Health Insurance Company processed the claims for Inpatient services to apply Non-Network Benefits appropriately in accordance with the Insurance Policy, Schedule of Benefits, and Network Addendum.
>
> Claims are processed based on the provider's participation status, regardless of the circumstance.

The policy, on page 8, provides that services are payable based on the network status of the provider:

> **SECTION 5. Obtaining Covered Services**
>
> * * *
>
> In order to receive Network services, you are responsible to ensure that the Provider participates in the Network at the time of service.
>
> * * *
>
> If you receive services from a Non-Network provider you will receive "Non-Network Benefits" (except as otherwise specified in this Policy). You will be responsible for the Copayments, Deductibles, Coinsurance and any amount over Reasonable and Customary shown under the heading of "Non-Network Benefits" in the Schedule of Benefits. . . .

Under the Petitioner's policy, inpatient care at an in-network hospital is covered at 100%, the same care at a non-network facility is covered at 80%. Similarly, the Petitioner's deductible for in-network benefits is $4,000.00 and $6,000.00 for non-network benefits.

The policy does not include any provision which would require that network benefits be paid for services provided at non-network facilities. The Commissioner finds that the PHIC denial of coverage at the network level is consistent with the provisions of the policy.

V. ORDER

The Commissioner upholds Priority Health Insurance Company's final adverse determination of April 29, 2011. PHIC is not required to provide network-level benefits for the Petitioner's November 11 through 13, 2010, medical care at a non-network facility.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.